Re-enrollment Form

Enroll people in Healthy Families who were in the program before

Instructions

Use this form to apply for people who were in the program ***before****. Copy this form if you need more room.*

If you have questions about whom to list or about income, see the* Family Members and Income *brochure that came with this form.

You must pay your first-month premium plus any past due premiums when you enroll. ***Call Healthy Families at 1-866-848-9166 to find out how much money to send with this form.***

Questions?

If you have any questions about the form, call Healthy Families: ***1-866-848-9166,*** *Monday to Friday, 8 a.m. to 8 p.m., or on Saturday from 8 a.m. to 5 p.m. The call is free.*

Family Member Number:

1. Persons you want to join Healthy Families who were in the program before.

If any information is wrong, please cross it out and write the correct information next to it.

Person	Relationship to	Date of birth	Gross income amount (income before taxes)	How often do you get income?
			$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month
			$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month
			$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month
			$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month
			$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month

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			$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month
			$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month

2. Have any of these persons received health insurance sponsored by an employer within the last 3 months? ❑ Yes ❑ No

If yes, which persons? _____

When did the insurance end? _____ Why did it end? _____

3. Other children in the household.

First name	Last name	Date of birth	Relationship to
			❑ Child ❑ Stepchild ❑ Other _____
			❑ Parent ❑ Stepparent ❑ Other _____
			❑ Parent ❑ Stepparent ❑ Other _____
			❑ Parent ❑ Stepparent ❑ Other _____

4. Adults in the household.

If any information is wrong, please cross it out and write the correct information next to it.

Name of adult	**Relationship to**	**Relationship to children**	**Gross income amount** (income before taxes)	**How often is the person paid?**
	Applicant	❑ Parent ❑ Stepparent ❑ Other _____	$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month
(First, middle and last)		❑ Parent ❑ Stepparent ❑ Other _____	$ Send proof of income	❑ once every week ❑ every two weeks ❑ twice a month ❑ once a month

5. Income deductions for expenses. Only list expenses paid by the adults on this form.

If you pay for child care or care for a person who is disabled, or if you pay court-ordered child support or alimony, you might be able to subtract (deduct) those costs from your household income. Fill in the information below.

You need to mail proof of expenses with this form. Proof might be copies of your bills or copies of a court order. *If you have questions about deductible expenses, see the* ***Family Members and Income*** *brochure that came with this form.*

Child care expenses you pay each month for *children* under age 2. (The maximum amount allowed is $200 per child.)	$ Send proof of expense
Child care expenses you pay each month for *children* age 2 and over. (The maximum amount allowed is $175 per child.)	$ Send proof of expense
Disabled dependent care expenses you pay each month. (The maximum amount allowed is $175 per person receiving care).	$ Send proof of expense
Monthly court ordered alimony you pay	$ Send proof of expense
Monthly court ordered child support you pay.	$ Send proof of expense
For each working parent, we will deduct up to $90 for work-related expenses.	

6. Sign the form.

I, the applicant, certify that the information provided is true and correct. I understand that a change in income from last year may result in a change in monthly premium or may make my child(ren) ineligible for the Healthy Families Program.

➨ Signature: _____ Date:_____

7. Authorization to forward Re-enrollment form to Medi-Cal:

If my child is ineligible for Healthy Families because my income is below Healthy Families guidelines, I request that this form be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief.

➨ Signature: _____ Date:_____

8. Permission to share information with the following person:

I give permission for the Healthy Families Program and Medi-Cal Program to give information over the telephone about the status of this application to a Certified Application Assistant of the Enrollment Entity organization identified. This permission will end on the date the program mails the results of the eligibility determination on this application.

Name: _____

➨ Signature: _____ Date:_____

CAA#: _____ EE#: _____

9. Mail or fax the form to Healthy Families.

Mail the form, proof of income papers and proof of expenses papers to:

Healthy Families Program
Program Review Unit
PO Box 138005
Sacramento, CA 95813-8005

Or, you can fax the form and papers to:

Fax: 1-866-848-4974 The fax number is free.